DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96 — 002

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/96

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 96 $ 20.5 m
b. FFY 97 $ 10.6 m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

RECEIVED
BOSTON REGIONAL MEDICAID
MAR 29 96

10. SUBJECT OF AMENDMENT:
Nursing Facility Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner, Division of Medical Assistance

15. DATE SUBMITTED:
xxxxxxxxx 3/29/96

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

ATTACHMENT 4.19-D (4)

The current nursing facility reimbursement system under the State Plan establishes prospective casemix rates that are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur to provide care in conformity with applicable state and federal laws, regulations, quality and safety standards, and the regulations developed by the Massachusetts Rate Setting Commission, "Prospective Rates of Payment to Long-Term Care Facilities" 114.2 CMR 5.00, as amended from time to time. The current set of these regulations, effective January 1, 1996 are attached hereto as Appendix 1. These regulations stipulate that the rates for rate year 1996 be based on audited cost reports for rate year 1993 (the "Base Year").

I. Cost Reporting and Cost Finding

A. Required Reports

Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. The cost-reporting form for the Annual Report is the same for all providers of long-term care and consists of the Rate Setting Commission's RSC-1 Report for an operating company, the RSC-2 Report for realty companies, and the RSC-3 Report for management companies, collectively referred to as" Reports". Every provider shall maintain a fixed asset ledger which clearly identifies each asset for which reimbursement is being sought, including its location, date of purchase, the cost, salvage value, if any, accumulated depreciation, and the disposition of sold, lost, or fully depreciated assets. Providers that claim management or central office expenses must file an RSC-3 Report. If additional management or central office expenses are claimed through more than one entity, each additional entity must file a management or central office expense report which are identified as RSC-3A, B, etc. When filing these Reports and incorporating such costs into the claim for reimbursement, the provider must certify that such costs are both reasonable and necessary for the care of publicly aided patients in Massachusetts. Management or central office organizations are subject to the same personnel and administrative standards as individual facilities. For example, written job descriptions for all positions including qualifications, duties, responsibilities, and time records will be maintained by management companies in order to have personnel costs considered for reimbursement. Providers shall also complete and file the Rate Setting Commission's wage surveys.

Providers that do not own the real property of the nursing facility and pay rent to either an affiliated or non-affiliated realty trust or other business entity, must file or cause to be filed an RSC-2 Cost Report in order to have the rental cost considered for reimbursement.

Accurate detailed financial records substantiating reported costs must be maintained for a period of at least five (5) years following the submission of such Reports or until the final resolution of any appeal involving a rate for the period covered in a report, whichever is longer.

Each provider must make such records available upon demand to representatives of the Rate Setting Commission or the Division of Medical Assistance.

B. Filing Dates: Reports

1. Reports. Every nursing facility is required to submit the Report(s) for each calendar year, along with any other information which the Rate Setting Commission may require, on or before 5:00 pm April 1 of the following year. Reports received after this due date are subject to the sanctions set forth in Section I. A. 7. herein, Failure to File in a Timely Manner. Where the due date falls on a week-end or holiday, the Report(s) shall be due by 5:00 pm on the following business day.

2. Change of Ownership. Where there is a change of ownership, the transferor shall file the Report(s) within sixty (60) days after the transfer of ownership. Where the transferor fails to submit the Report(s), the Rate Setting Commission may request the Division of Medical Assistance withhold payment to the transferee until such reports a appropriately filed.

3. New Facilities and Facilities with Major Additions. For the first two calendar years of operation during which New Facilities and Facilities with Major Additions receive prospective rates of payment ***(see Section IV, herein)***, such facilities shall file year-end Cost Reports within sixty (60) days after the close of the calendar year.

4. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility which is licensed for both hospital and long-term-term care services, where the long-term-term care beds were converted from licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Report(s) on a fiscal year basis which is consistent with the filing of such

facilities' hospital cost reports. The Report(s) shall be due no later than ninety (90) days after the close of the facility's fiscal year.

C. Extension of Filing Date

The Rate Setting Commission may grant an extension, up to forty-five (45) days, for submission of the Report(s). A request for an extension must: (ã) be submitted in writing to the Rate Setting Commission by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. Incomplete Submission

The Rate Setting Commission shall notify the provider within one hundred twenty (120) days of receipt of the Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with the Rate Setting Commission within twenty-five (25) days of the date of notification or by April 1 of the year the Report is filed, whichever is later. The Reports and all accompanying schedules shall be deemed to be filed with the Rate Setting Commission as of the date the Rate Setting Commission receives the complete submission.

Example: Where a provider files the 1995 Report(s) on March 20, 1996 and the Rate Setting Commission notifies the provider on March 25, 1996 that it finds the submission incomplete, the provider must submit all additional information by April 19, 1996 in order for the submission to be complete and the Report deemed filed with the Rate Setting Commission on time. In such cases, sanctions pursuant to Section I A.7 of this plan amendment shall not be applied.

If the Rate Setting Commission fails to notify the provider within the 120-day period, the submission shall be considered complete and the Report(s) and all accompanying schedules shall be deemed to be filed with the Rate Setting Commission as of the date of receipt.

The Rate Setting Commission's right to request additional data and information during a desk or field audit, pursuant to 114.2 CMR 5.03(6) (see Appendix 1) is not limited by these provisions.

E. Amended Reports

The Rate Setting Commission shall not accept amended Reports except as provided in 114.2 CMR 5.04 (9) (see Appendix 1).

F. Additional Information

In addition to requests for information and data made pursuant to a desk or field audit, the Rate Setting Commission may seek additional information and data relating to the operations of the provider and related parties, if any. Any provider who fails to maintain records shall have excluded from its prospective rate calculation any cost or item for which records were not maintained. Any record not produced at the request of the Rate Setting Commission shall be deemed not to have been maintained.

G. Failure to File in a Timely Manner

1. The sanction imposed for each 30-day period or any portion thereof, of which acceptable Report(s) are received after the due date, shall be a one-month delay in the new rate set for the facility for the next calendar year. Such sanction shall be imposed only when the new rates set for the facility are greater than the rates in the current year.

2. If a provider fails to file the Reports or other required information within six (6) months of the filing date, the Rate Setting Commission shall notify the provider of this failure and the sanctions which shall be imposed. Notification shall be sent registered mail, return receipt requested. Unless the failure to file is cured, the Rate Setting Commission will terminate the prospective per diem rate of the provider effective the following January 1. If the provider subsequently files the required reports, the termination will be rescinded by the Rate Setting Commission.

Example: When a provider fails to file the 1995 Report(s) by September 30, 1996, the Rate Setting Commission shall notify the provider of the failure to file. If the Report(s) are not filed by December 31, 1996, the provider will receive zero rates for the entire 1997 Rate Year. However, if the provider files the Report(s) on November 12, 1996, the provider's prospective per diem rates for the months of January through August of 1997 shall be the 1996 prospective rates, except when the 1997 prospective rates are lower than the 1996 rates.

H. Termination of Provider Contract

Whenever a provider contract between the provider and the Division of Medical Assistance is terminated, the provider shall file Reports covering the current reporting period or portion thereof covered by the contract and any other Reports required by the Rate Setting Commission, within sixty (60) days of such termination. When the provider fails to file the required Reports in a timely fashion, the Rate Setting Commission shall notify the provider of this failure by written notice sent registered mail, return receipt requested.

Facilities that are under the supervision of a Patient Protector Receiver appointed by court order or a trustee in bankruptcy will be treated as a termination of provider contract for purposes of this subsection. For example, if a Patient Protector Receiver is appointed on August 15, 1996,

the cost report for the period January 1, 1996 to August 14, 1996 and all prior Reports are due on October 15, 1996.

I. Reporting Requirements for Facilities that are Partially Converted to Assisted Living programs.

When a portion of a facility is converted to an Assisted Living Program, the Provider shall establish that program as a separate business entity, with separate books and records. Such books and records must be available to the Rate Setting Commission to ensure that all costs occurring in the facility are properly accounted for among the programs. (A) The existing building and improvement costs associated with the Assisted Living Program are to be identified and removed from the prospective per diem rates on a square footage basis; (B) The existing equipment which is no longer used in the long term-care operations are to be identified and removed from the nursing facility records and from the claim for reimbursement; (C) Additional capital expenditures which are acquired to implement the Assisted Living Program shall be directly assigned to that entity; (D) All shared costs, including shared capital costs, and allocations must be based upon a well documented and reasonable assignment of costs based on benefits derived from such costs; a reasonable assignment of costs is determined by excluding any costs which are not related to or necessary for the care of publicly aided patients in nursing facilities; (E) A plan for such sharing and allocation which demonstrates the rationale and supporting statistics for that plan, must be submitted to the Rate Setting Commission prior to the beginning of each reporting period.

J. Reporting Requirements for Hospital-Based Nursing Facilities.

In addition to the reporting requirements set forth in Section I A. 2. herein, Filing Dates, the following reporting requirements exist for Hospital-Based Nursing Facilities:

1. Building and Improvement costs associated with the space actually used for long term care purposes are to be identified and included on the RSC-1 Cost Report.

2. Hospital-based nursing facilities must report Major Moveable Equipment and Fixed Equipment in a manner consistent with the RSC-403 Cost Report. These facilities must also classify Fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 5.02 (see Appendix 1). A Hospital-based nursing

facility may elect to be reimbursed for Major moveable and fixed equipment by one of two methods;

a. A facility may elect to specifically identify the Major Moveable Equipment and Fixed Equipment which is directly related to the care of Publicly-aided patients in the Nursing Facility. This specific identification option must be supported with complete documentation which clearly identifies each piece of equipment in a fixed asset ledger, including its cost, date of purchase, and accumulated depreciation, Such documentation must be submitted to the Rate Setting Commission with the first RSC-1 Cost Report filed with the Bureau of Long-term Care. If the facility provides such documentation, the assets will be reimbursed in the facility's allowable basis pursuant to 114.2 CMR 5.10 or 5.20. (see Appendix 1).

b. If the facility elects not to identify specifically each item of Major Moveable and Fixed Equipment, Major Moveable Equipment will not be allowed as part of the facility's allowable basis. Fixed Equipment will be recognized by an allocation made on a square footage basis as set forth above in ***section 1.***

3. Additional capital expenditures that are directly related to the establishment of the nursing facility within the hospital shall be reported under additions on Schedule 15-Claim for Fixed Costs of the RSC-1 Cost Report. Capital expenditures associated with the total plant will be allocated utilizing the square footage statistic established in ***section 1*** above.

4. Direct costing shall be used whenever possible to obtain operating expenses associated with the nursing facility. All shared costs shall be allocated between the hospital and the nursing facility using the statistics specified in the RSC-403 Cost report instructions.

5. Costs related to the acquisition of the licensed nursing facility beds will neither be reimbursed nor included in the allowance.

6. Except for the provisions described in Section I.J. herein, Reporting Requirements for Hospital-Based Nursing Facilities, such facilities shall not be treated differently from other providers.

II. Methods and Standards Used to Determine Payment Rates

A. Prospective Per Diem Rates

The prospective rates of payments shall be established on an annual basis, as set out in 114.2 CMR 5.04 (see Appendix 1) through 5.22 and shall be computed on a per diem basis from the Base Year Reports. Facilities which were transferred during the base year shall have their prospective rates computed from the transferor's cost report or by consolidating the allowable expenses from the Reports of both the transferor and transferee, as determined by the Rate Setting Commission according to 114.2 CMR 5.04(1)(a) (see Appendix 1)

The prospective rates of payment shall be established whenever possible on the basis of on-site audited data; otherwise, they shall be established on the basis of data which has been the subject of a desk audit. Costs and expenses included in determining a provider's rates of payment are subject to all limitations and conditions set forth in 114.2 CMR 5.00 et seq. (see Appendix 1). In the case of nursing facilities which include resident care units, separate prospective per diem rates shall be computed for those beds licensed for residential care.

Facilities which have been closed and then reopened will have their Prospective Per Diem Rates computed using the Base Year cost Report(s) of the same facility. In the event that, for any reason, the Base Year cost Report(s) has not been filed, the latest available cost Report for that facility will be used. When that occurs, the Reasonable Variable Costs and Reasonable Nursing Costs will be increased by an appropriate Cost Adjustment Factor, ***as determined in Section B.3. below,*** and the Administrative and General Allowance will be established at the Base Year median.

B. Computation of the Prospective Rates

1. Methodology

The Rate Setting Commission, in computing prospective rates, shall:

a. determine the allowable and reasonable costs for each cost center;

b. divide the allowable and reasonable costs for each cost center by a divisor as determined in 114.2 CMR 5.04(3)(b) (see Appendix 1) to get a per diem rate for each cost center;

and

c. aggregate the various per diem rates for each cost center and add the cost adjustment factor as determined in 114.2 CMR 5.04(3)(c) to the per diem rates determined in 114.2 CMR 5.06 and 5.09 (see Appendix 1).

2. Divisor

The divisors used are different for different centers.

a. The divisor used for the Nursing and Variable and Administrative and General cost centers shall be the greater of base-year (1993) patient days or ninety-six percent (96%) of licensed mean beds in the base year times days in the base year.

b. The divisor used for the Director of Nurses cost center shall be current licensed beds times the days in rate year times the greater of ninety-six percent (96%) or the actual utilization rate in the base year.

c. The divisor used for the Motor Vehicle, Equity, Use and Occupancy Allowance and Miscellaneous cost centers shall be current licensed beds, including resident care units, times the days in the rate year times the greater of ninety-six percent (96%) or the actual utilization rate in the base year.

d. The divisor used for Capital Costs, Fixed Costs and Depreciation (excluding motor vehicle depreciation) shall be the Constructed Bed Capacity times the days in the Rate Year times the days in the Rate Year times the greater of ninety-six percent (96%) or the actual utilization rate in the Base Year.

3. Cost Adjustment Factor

The Cost Adjustment Factor is a multiplier which generates an amount to be added to reimbursable base-year costs. In calculating the prospective rates for long-term care facilities, the value of the cost adjustment factor multiplied by the reimbursable base-year (1993) costs, exclusive of all fixed costs shall be added to

reimbursable base year costs. Where there has been a change of ownership in the base year and the prospective rates have been based on the new owner's reporting period costs pursuant to 114.2 CMR 5.05(1) (see Appendix 1), the cost adjustment factor shall be modified to reflect the number of months from the midpoint of the reporting period to the midpoint of the prospective rate period. For prospective rates effective January 1, 1996, the cost adjustment factor from 1993 through 1995 shall be 5.52%. ***The total CAF has a labor and non-labor component. The sources are: Most Optimistic Massachusetts CPI, and DRI Forecast based on HCFA Nursing Facility Market Basket.***

C. Cost Centers

The calculation of the Prospective Per Diem Rates for each individual provider is based upon the allowable costs and expenses in each cost center under the provisions and limitations set forth in 114.2 CMR 5.05 through 5.22 (see Appendix 1). The different cost centers are set forth in 114.2 CMR 5.04(2).

1. Reasonable Variable Costs

Reasonable variable costs, limits, and grouping for representative sampling are described in 114.2 CMR 5.06 (See Appendix 1). The limits for these reasonable variable costs are as follows:

Limits for Reasonable Variable Costs

Groups	Variable Cost Limits
(a) Group 1 = Facilities in Case-Mix Group-Light and located in Health System Areas 4a and 4b;	$35.73
(b) Group 2 = Facilities in Case-Mix Group-Heavy and located in Health System Areas 4a and 4b;	$37.76
(c) Group 3 = Facilities in Case-Mix Group-Light and located in Health System Areas 1, 2, 3, 5, and 6;	$34.12

(d) Group 4 = Facilities in Case-Mix Group-Heavy and located in Health System Areas 1, 2, 3, 5 and 6. $36.46

Calculation of Allowed Variable Costs. The Rate Setting Commission shall calculate the allowable variable costs subject to the limitations set forth above, and apply the Cost adjustment Factor set forth in Section II B. 3. of this plan amendment. This amount shall then be increased by 2.52% and will be Allowable 1996 Variable Costs. ***The 2.52% increase is a 1995-1996 adjustment factor which has a labor and non-labor component. The sources are: Most Optimistic Massachusetts CPI and DRI Forecast based on HCFA Nursing Facility Market Basket.***

2. Director of Nurses

Limitations. For the position of Director of Nurses as required by the Department of Public Health, allowable cost shall be held to the limits set forth in 114.2 CMR 5.05(4)(m) (see Appendix 1).

Reasonable Costs. Reasonable Operating Costs associated with the position of Director of Nurses shall include salary, fringe benefits, payroll taxes, and workers compensation.

Calculation of Allowable Director of Nurses Costs. The Rate Setting Commission shall calculate the allowable 1993 Director of Nurses Costs subject to the limitation described above, and apply the Cost Adjustment Factor set forth in Section II B. 3. of this plan amendment. This amount shall then be increased by 2.52% and will be the Allowable 1996 Director of Nurses cost.

3. Administrative and General Costs

Administrative and General Costs are paid as an allowance. For rates effective January 1, 1996, such allowance shall be set at $9.74 per diem. However, any facility that has a Base Year Administrative and General Cost per diem that is less than this allowance shall have its allowance calculated as set forth in 114.2 CMR 5.08(2) (See Appendix 1).

4. Reasonable and Allowable Nursing Costs